From the President...
Loralie Ma, MD

The phrase “knowledge is power” is a well-known proverb, and one that I believe to be true. Especially when it comes having knowledge about your value, your worth, as a working physician today. At MedChi, we strive to give you the information, the tools, and the resources to help “empower” you in your role, no matter what practice model. Following are some of the many resources MedChi provides under the category of “Your Profession” (literally — this is the name of the tab on MedChi’s website: https://www.medchi.org/Your-Profession).

The Center for the Employed Physician (www.medchi.org/Center-for-the-Employed-Physician) includes tools to help physicians negotiate optimal contracts with their employers, avoid common pitfalls in contracts that can erode negotiating power, and illuminates the differences in the various types of employment models available to physicians — including HMOs, major hospital systems, and venture capital-backed entities — which are becoming more and more commonplace.

Are you curious about where your salary “sits” on the salary curve in the Maryland market? Would you like to examine a “model employment contract”? Both are available as a members-only benefit; simply visit the Center for the Employed Physician and click on the appropriate button.

For those considering starting their own private practice or joining one, I encourage you to visit the Center for the Private Practice of Medicine (again, under Your Profession) as it’s chock full of information and useful links! The Center’s resources cover everything you need to know under “practice management help and guidance,” including practice operations, workflow assessment, technology services, HIPAA compliance, billing and coding, and insurance — to name a few.

The Center for Value-based Care is a newer page, and MedChi leads the charge in protecting physician interests as Maryland health care shifts to value-based care. When value-based care first emerged on the scene (originating from The Centers for Medicare and Medicaid), MedChi aimed to provide physicians with equitable programs that rewarded physicians for providing quality care, including cost-saving preventive care that reduced or eliminated unnecessary hospitalizations. Programs such as EQIP and MDP CP, which operate under Maryland’s Total Cost of Care (TCOC) Model, build on the success of the Maryland All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care.

Being informed and being knowledgeable about your options, is empowering, which is at the heart of this issue. If you like what you read, many of the authors on the following pages will be speaking at our upcoming “Physician Empowerment Summit” on November 5, 2022. You can access the full agenda by clicking on the QR code, below. I hope to see you there.

What You Need to Know Now

1. Effective October 1, Senate Bill 394: Statewide Targeted Overdose Prevention (STOP) Act of 2022 requires community service programs — such as homeless service programs and outpatient treatment programs to offer an opioid reversal medication approved by the FDA free of charge.

2. Effective October 1, Senate Bill 62/House Bill 28 allows pharmacists to prescribe nicotine replacement therapies. Up until September 1, 2023, the Board of Pharmacy is required to issue regulations governing prescribing, training requirements, and standards of practice for pharmacists to follow.

3. Effective October 1, House Bill 1127 requires CRISP to operate as a "health data utility," which will provide data to individuals and organizations involved in the treatment and care coordination of patients. The MHCC will be developing regulations for the implementation of this legislation and CRISP will be establishing a Consumer Advisory Council to advise on the delivery of CRISP services.

To review any bill in its entirety, visit www.mgage. maryland.gov.
Solo Practice Without Regret

State Delegate Terri Hill, MD

While I would like to say that my decision to enter private practice at the beginning of my career was made after thoughtful contemplation and informed consultation, that would not be the truth. Like many residents and fellows approaching the end of their training, there were a few things I knew I wanted to be part of my future career, many things that I did not, and other things I was open to considering. Some were in my control, some not so much.

My options for entering clinical practice, as I saw them, were to (a) continue in academia, (b) join a practice, (c) join the military, or (d) hang my own shingle.

I completed my training in New York and Miami and returned home to Columbia, Maryland, in July, having done little to make myself familiar with or known to the academic plastic surgery programs or private practice plastic surgeons in the Baltimore/DC area. I do not recall accessing job posting boards, engaging professional headhunters, inquiring about associate positions that were opening, or even setting up interviews with practices in the months preceding my fellowship's end. My pitch to my network of mentors, professional and family connections, and community physicians was that I was an enthusiastic, well-trained, freshly minted surgeon ready for hire.

During one interview, a colleague who regularly employed associates told me, "It takes two years to regain the investment I put into bringing an associate aboard, and only six months for them to realize they can do this on their own." He suggested that I stop looking to be hired and move instead to opening my own practice. He knew my background, had spoken with my program attendings, and assured me I had the knowledge, training, and skills to do it. And I did.

There is no question that going directly from a specialty fellowship to solo practice, particularly in a location where one didn't train, presents significant challenges. To be fair, there are challenges to transitioning from training to practice regardless of how it is done. To relocate, build professional relationships, and establish a patient base are shared challenges, regardless of whether one joins a group, enters academia, or establishes a solo practice. In the first two situations, however, one benefits directly from the professional networks, management infrastructure, and other relationships of those who you are joining. There is also a cost: joining a group generally requires filling a role.

What solo practice lacks in support, is made up for in autonomy. Autonomy for me is largely guided by two things — what do I need to do to be happy doing my job and what do I need to do to be successful in my job. As a solo practitioner I get to define what success means without having to meet metrics imposed by others. Success might be defined solely by income, largely a function of one's professional accomplishments or acknowledgments, based on expressed patient appreciation, a reflection of the extent community impact, judged by family advancement, measured by the sustained ability to meet payroll, or be dependent on the practice's growth over time.

However I define success, I shape and change my practice to suit my needs. Obligated only to consider my patients, family, staff, and myself, I decide what networks, if any with which to participate, what type of cases to see, what hours to work, and who to hire. I decide which hospitals do or don't have privileges, and the number and locations of offices and clinics from which to work. When to make changes in each of those things.

While I've made decisions that I wish I'd made differently, and not every decision has led me where I'd expected and hoped it would, I relish that the choices were mine. And while solo practice can at times feel overwhelming, colleagues who have chosen other professional structures are negotiating the same types of crossroads.

As medical professionals, we are fortunate to have throughout our careers options for how we use our degree. We have the flexibility to change direction, setting, location, responsibilities, even country. We can choose research, academia, consultative corporate work, health systems management or administration, journalism, or clinical practice under a variety of structures, as examples. Changing directions during a 40–50-year career is not unusual, and having additional degrees such as an MPH, MBA, or JD open even greater possibilities.

The flexibility and autonomy of solo practice has given me the opportunity to contribute for an extended period to my community in ways that would have been hard to do otherwise.

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The Myth of the Standard Contract
Stephen H. Kaufman, Esq.

Is a job change or contract renegotiation in your future? Here is a true cautionary tale (the names were changed to protect the innocent) followed by some tips to get a better deal.

Dr. Billy Rubin was finishing residency at Big City Mega Hospital and looking for his first job. After an exhaustive search, Billy decided that his best opportunity was with a multi-office private practice run by Dr. Arnold Chiari. The job was perfect. Everyone said that Dr Chiari was a reasonable, fair boss. The hours were good and the pay competitive. Best of all, Dr Chiari repeatedly promised Billy that he would work only at the Practice’s Northern Suburbs office, which for personal reasons, was extremely important to Billy.

To Billy’s delight, Dr. Chiari offered him a job, sending him the practice’s standard contract. Billy read it carefully. He wasn’t sure that he understood it completely but comforted by his interviews, thrilled to have a job in the perfect place and loathe to risk annoying Dr. Chiari by trying to negotiate, Billy signed the contract with no changes.

A few months later, Billy graduated from Mega Hospital and, together with his wife and daughter, moved to their new home in Northern Suburbs. After a few weeks off, Billy started work. Practicing with Dr. Chiari was different from training, but Billy liked his colleagues, the office was state-of-the-art, and the short commute to work was great. All was as promised. Billy was happy.

The bliss was short-lived. After three months, there was yet another exodus from the practice’s chronically understaffed Center City office and Dr Chiari told Billy that he was being transferred there to work the 1p.m. to 9 p.m. shift, effective immediately. Greatly upset, Billy complained, to no avail. Seeing no other solution, Billy called his lawyer to fight this injustice.

Billy’s lawyer reviewed his contract. He then shocked Billy, telling him that, legally, Dr. Chiari could require Billy to transfer because his “standard” contract did not say that Billy would work only at the Northern Suburb office. Instead, it said that he “would work at the Northern Suburb office or at such other office(s) as he may be assigned”. Billy could ask for relief. He could beg. He could quit. What he could not credibly do was accuse Dr. Chiari of breaking the contract. Billy had agreed that he could be moved.

Billy’s situation may seem unlikely or unbelievable. Believe it. Being moved around or having one’s hours increased or changed for the worse is surprisingly common. To help avoid these and countless other problems, remember the following four rules.

Rule 1. The more fully and accurately your contract sets out your deal, the better off you will be. Despite common perception, a contract does not create a deal, it documents one. View your contract as a comprehensive job description that sets out your and your employer’s obligations to one another. If done right, a contract fairly and unambiguously sets out the agreed business arrangement with each side knowing what is expected of itself and the other side. Your contract should match what you were promised and everything important to you should be in it. There should be no unwritten side deals, often couched as: “trust me we would never do to you what your contract says we can do.” Trust at your peril. Legally, communications made prior to signing a contract almost always disappear when you sign. And even if you trust the person making the extra-contractual promises, people forget or move on and, when push comes to shove, institutions look out for their own best interests, not yours.

Rule 2. Your contract is not in English. To non-lawyers, contracts often appear to be in Standard English. They are not. Many benign-looking words are anything but. Like insider technical doctor language (think epistaxis or pyrexia), lawyers have words whose meaning is best known to lawyers. Consider “sole discretion”, as in: your employer decides in his or her sole discretion whether your skills are sufficient to keep your job. This seems reasonable unless you know that in legalese, “sole” means “arbitrary” and unchallengeable. Good lawyers write contracts more carefully than non-lawyers usually read them. Not only do individual words matter, punctuation matters. It’s not unusual for substantial sums of money to change hands based on the placement of a comma.

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We Must Be Our Patients’ and Our Own Best Advocates

Peter B. Sherer, MD, FACS

Someone told me years ago that once you are accepted by a medical school, your life forever changes. Certainly, medicine is much more than just a job. We have all been fortunate to be in such a wonderful profession. We have been entrusted with the health and lives of our patients, have had a large impact upon public health, and are continually intellectually stimulated.

This year I retired from my internal medicine, hematology-oncology practice and attended my fiftieth medical school reunion. Retirement was a bittersweet decision, but I was fortunate that another physician took over my practice, ensuring continuity of care and eliminating the stress of storing thousands of paper charts (yes, you read that correctly).

Over the years I encountered a vast number of memorable and interesting patients, many of whom I regarded as friends. I like to think I made a difference in their lives, improving their health, reducing suffering, prolonging survival and giving them hope and solace.

The Montgomery County Medical Society and MedChi played a major role in my career. I became active virtually from the very start and served on several committees. I have been a long-time delegate to MedChi and previously served as secretary. I was the editor of Montgomery Medicine and a past president of MCMS.

I enjoyed the many benefits of membership, including the camaraderie, the educational and practice management session, the many social activities, and lobbying efforts in Annapolis and Washington. The society and its excellent staff provide great service to its members and I urge everyone to get involved and stay involved.

The many medical advances over the past four decades have been astonishing. I went through my entire internship without the benefit of getting a CT scan, let alone an MRI, PET, or PET/CT. Combination chemotherapy was in its infancy and there was no targeted therapy or any of the multitude of new drugs which seem to pop up monthly.

We continue to face many challenges to our profession from many fronts, and we must be our patients’ and our own best advocates. The need to obtain prior authorization is frustrating, exasperating, and time-consuming. To have to spend hours getting a standard of care medication approved by a clerk who cannot even spell the name of the disease is criminal. I knew it was time to retire when I received a letter from Medicare informing me that I had ordered too many cholesterol tests in 2019.

In recent years I participated in an accountable care organization, which focuses on keeping patients healthy, mostly by adhering to various quality of care measures. In that regard, the nurse managers were extremely helpful, but I soon discovered that complying with quality measures was easier than reporting them. Furthermore, if a patient refused to get a mammogram or a flu shot, the physician lost metric points for quality of care.

The challenge in our profession is to not allow the many frustrations detract from the joy and gratification obtained from practicing medicine. The intellectual stimulation and patient interaction more than make up for all the negatives.

Try to maintain your curiosity, empathy, and sense of humor and enjoy the adventure of being a physician.

Peter B. Sherer, MD, FACS retired from private practice in 2022. He can be reached at sherer32@gmail.com. He is now playing more golf, reading, and volunteering at community clinics in the area.
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CareFirst Dispute Shines Light On Issues Caused By Insurance Monopoly

Gene M. Ransom III

A contract dispute between Maryland’s world-renowned and award-winning hospital system, Johns Hopkins, and insurer CareFirst BlueCross BlueShield, concerns everyone, but it shouldn’t come as a surprise. Structural problems with the health insurance system are at the root of this dispute, and it’s time we had a conversation about health insurance concentration in Maryland.

MedChi, The Maryland State Medical Society, has raised concerns about the Maryland health insurance market for years. Several years ago, we proposed legislation simply requesting a study of the insurance concentration in the state, which did not even receive a vote due to CareFirst’s opposition. According to the most recent “AMA Competition in Health Insurance Study” CareFirst controls more than 50 percent of most Maryland markets; in some parts of Maryland, they control 70 percent of the market. This large market share makes it very difficult for practitioners to negotiate fair rates with CareFirst.

These challenges are compounded by Maryland’s unique hospital reimbursement system, where Medicare and Medicaid pay more for hospital-based care in Maryland than the rest of the nation, and commercial insurers pay less. Even though we know that CareFirst and other insurers pay about 25 percent less for hospital care compared to the rest of the country, it doesn’t equate to lower premiums paid by employers and individuals. In fact, MedChi just raised concerns about CareFirst’s recent rate filing that included a premium rate increase request. Between 2017 and 2020, CareFirst increased its commercial premiums by an average of 3.3 percent annually in Maryland (and 4.7 percent in Washington, DC). CareFirst may claim that rate increases to providers will cause premium increases, but given these facts, it’s not clear why paying physicians, or Johns Hopkins, reasonable rates would translate into higher premiums.

If CareFirst is underpaying doctors and nurses and getting a discount on hospital care, but not charging its members lower premiums, the question is where is all that money going? We know it’s not going to caregivers. Physician reimbursement in Maryland is one of the worst in the nation. According to a recent study by the Maryland Healthcare Commission, Maryland is ranked third worst in the nation for physician reimbursement.

The non-payment of practitioners by the dominant carrier is exacerbated by the fact that the cost of providing care keeps going up. According to Johns Hopkins, CareFirst has increased what it pays their doctors and nurses by just 10 percent even though the cost to deliver care has gone up 21 percent. I have heard from other physician members these numbers are similar in their practices as well.

Hopefully the parties will reach a fair agreement by the December 5 deadline. Everyone wants Johns Hopkins doctors and nurses to stay in the CareFirst network, and that there is no impact on the cost of care at Hopkins for people with CareFirst health insurance. No matter how this is resolved, we need to look at the balance of power in the health insurance market; competition would result in a better marketplace for physicians, patients, and the public health of Maryland.

Gene M. Ransom III is the CEO of MedChi, the Maryland State Medical Society.
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Equal Pay Counts: The Ongoing Work of MedChi’s Gender Pay Equity Subcommittee

Carolyn B. O’Conor, MD, FAAFP, with Victoria Hecht

Background
At the April 25, 2021, meeting, MedChi’s House of Delegates adopted a resolution to address the issue of persistent gender pay gap in medicine. The measures adopted took their direction from the policy and directives of the American Medical Association (AMA), and included:

- supporting institutional, departmental, and practice policies that offer transparent criteria for initial and subsequent physician compensation, consistent with Maryland law;
- Continuing to advocate for pay structures based on objective, gender-neutral criteria;
- Promoting an awareness of means of identifying and reporting violations of the Maryland Equal Pay for Equal Work Law, which bars employers from discriminating among employees with regards to wages and less favorable opportunities;
- Advocating for training to identify and mitigate implicit bias in compensation decision-making for those in positions to determine salary and bonuses, with a focus on how gender can contribute to bias in the evaluation of physicians which may impede compensation or career advancement.

Included in the resolution was a proposal for MedChi to collect and analyze comprehensive demographic data and produce a study on gender equity, including, but not limited to, membership; representation in the House of Delegates; reference committee makeup; and leadership positions within MedChi, and to disseminate such findings in regular reports to the House of Delegates, beginning in Fall of 2022 and continuing yearly thereafter, with recommendations to support ongoing gender equity effort.

Process
Founded in October 2021, the Gender Pay Equity Subcommittee meets once a month to clarify and advise MedChi’s position on gender pay equity in medicine and provide clear and purposeful recommendations on how MedChi can further promote the advancement of this cause including, but not limited to, suggestions for decisions, initiatives, and resources for members and the medical community at large. The Subcommittee is chaired by Carolyn O’Conor, MD, with MedChi Chief of Staff Catherine Johannesen providing advisory and operational support.

Recognizing that gender pay inequity is an ongoing and systemic problem that cannot be solved overnight, and that more data is needed before recommendations can be made for regulatory and/or legislative action, the Subcommittee has turned its attention to opportunities designed to enhance awareness of the problem, inspire engagement among their peers, remind the public that the problem exists, and show those in positions of negotiating salary or career advancement how this can be addressed. With these goals in mind, the committee is focusing its efforts in three major areas — public programs, media, and peer-to-peer engagement, all designed to enhance public awareness and foment action:

Public Programs: A Storytelling project is in the works. The purpose of the project is to use the power of storytelling to illustrate the effects of gender pay discrimination and remind us of its prevalence in the workplace. While it’s important to tell the negative stories, the subcommittee also hopes that positive stories are shared as well, so that others may learn from successful contract negotiations and other positive outcomes. These stories are intended to be educational and helpful, and not merely commiserating. The audience for this project will be residents and early-career physicians. The committee envisions a podcast episode (or more than one), hosted by Stephen Rockower, MD, in which female physicians will anonymously share their experiences with gender bias and pay inequity. The format will be interview-style; Dr. Rockower will moderate. Following the discussion, resources will be provided.

Media: A Scientific paper co-authored by members of the committee, based on the 2021 Maryland Physician Compensation survey produced by Merritt Hawkins, is in progress. Padmini Ranasinghe, MD, is spearheading this project.

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Nine Steps To Develop and Maintain a Successful Private Practice
Kate Gilman, CPC, CPCO

Successful Private Medical Practice means independence, high revenue, efficient day-to-day operations, happy providers, happy administrative and medical staff, happy patients, great patients’ ratings, great reputation in the community, and prosperous predictions for growth, which ultimately create a significant leverage in the market space. We’ve identified the following ten action-items that are necessary steps on the path to a successful practice. Even if you are just looking to jump-start your current practice, this list will give you a fresh outlook.

Step One: Dream Big! Create a vision and write out a plan for your ideal practice, down to the tiniest details, including what services you would offer, where you would like to practice, hours of operation, number of staff you would employ, and where you envision the practice being, five years from now.

Step Two: Create a “dream team” of consultants. Begin by gathering names of reputable healthcare attorneys, accountants, and job recruiters. Dedicate the time to interview at least two vendors from each industry. It is important to hire vendors with healthcare experience, as they will be most familiar with nuances in the healthcare industry. Consider a five-year financial plan with a safety net built in for unexpected emergencies (i.e., COVID-19).

Step Three: Find the right office space. There are several aspects to consider: location, demand for your services in the area, price, room for growth, layout and design, and terms of contract. Choose an experienced realtor who understands the medical space and can provide good recommendations. A commercial real estate agent can assist with contract verbiage and negotiate terms and conditions that can save you money in the long run. If you are currently in a lease and not sure how to exit without penalty, now is a good time to seek outside advice.

Step Four: Set up your office support system for utilities, phone and internet connections, office and medical supplies, and electronic health records system (EHR). Choose an EHR that has the capability to create multiple templates and can integrate seamlessly with other systems. You might also look for a practice management component with a comprehensive reporting system. While there is no one perfect system for every office, the best can help you to be more efficient, productive, and pro-active.

Step Five: Hire the right staff. The current job market in Maryland is nothing short of challenging for employers; staff openings are abundant and qualified candidates have a good deal of leverage. Professional recruitment firms are the best tools for finding top-notch candidates, followed by aggregate web sites in the health care space. Do not attempt to do a search by utilizing generic classifieds on non-healthcare platforms. While this may be tempting in the interest of saving money, it will only cost you time and resources. Employee retention is just as important as new hires. Always create an office environment where your employees feel appreciated and valued.

Step Six: Follow proper coding and billing procedures. Keep yourself and your staff up-to-date on federal and commercial payor guidelines; subscribe to payor newsletters and keep current on the changing laws. Local and national medical societies and healthcare organizations are great resources to finding the most updated information.

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Rule 3. Your contract was written to protect your employer, not to protect you (or to accurately set out your deal). Every lawyer must look out for his or her client’s best interests above all else. That means that the contract you are first given will be somewhere between mildly unfair to you and outrageously oppressive. You need to identify where your contract falls on the spectrum so that even if you can’t improve it through negotiation, you will be forewarned about your employer’s attitude toward her workers. Or perhaps you will decline the job.

Rule 4. Negotiate! This is the most important rule. All contracts are negotiable, so negotiate! You might not get all that you want, but it is 100 percent guaranteed that if you don’t ask, you won’t get it. Some employers will go to great lengths to convince you that their contract is unchangeable. They will tell you that the contract is “standard” or they will have pre-printed “Terms and Conditions” that look like a form. Often, they cite a need for institutional conformity and fairness as an excuse: “we need to treat everyone the same — you can’t have a better deal than the others.” This is almost always untrue. The “standard” contract is a myth perpetuated by employers to get you to sign a contract that is bad for you. All doctors in an organization do not have the same contract. They have different pay, different hours and different non-competes. Contracts are often changed. This year’s “standard” is next year’s trash.

Even if your employer claims that negotiation is futile, try anyway. You may be surprised and improve the terms of the job. Anticipating negotiation, most employers don’t start with their best deal. Negotiating can also teach you important things about your prospective employer. If an employer is rude, dismissive, or patronizing when you make polite, professional requests, imagine how you will be treated after you sign. Finally, negotiation will give you an opportunity to ask important questions about the job that were left unasked in interviews — like how the bonus plan really works or whether there is a possibility that you will be transferred. Passively accepting a contract as standard and nonnegotiable is for the naive. Negotiate. If you are reasonable and professional, the worst that should happen is that you will be told “No.”

Stephen H. Kaufman is Founding Partner at RKW Law Group. He will be speaking about Contract Negotiation for Employed Physicians at the Empowerment Summit on November 5, 2022.

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Solo Practice, continued from pg. 3

I’ve paid some costs, of course, but the price has been one I was willing to bear. More importantly, the decision to do so did not come with an ultimatum because of its impact on others in a group.

For me, solo practice has been a best fit. I am grateful to have been encouraged to trust myself to take the risk, and to have had the required support from others to sustain it through many iterations. So, while I cannot say that I will wind down my career still a solo practitioner, I can say that going into solo practice at the start of my career was the best decision for me. Had I to do it over, I would make it again.

Terri Hill MD, is plastic surgeon, in practice since 1991, and is Board Certified by the American Board of Plastic Surgery and a member of the American Society of Plastic Surgeons. She has been a member of the Maryland General Assembly since 2015, serving as a State Delegate for District 12.

Equal Pay Counts, continued from pg. 9

Peer-to-Peer Engagement: Gender Pay Equity will be one of the topics included in the plenary session of the “Physician Empowerment Summit” on November 5, 2022; following the session there will likely be a break-out group afterwards.

The Gender Pay Equity Subcommittee meets virtually on the second Tuesday of every month. If you are interested in becoming a member, please contact Vhecht@medchi.org.

Carolyn B. O’Conor, MD, FAAFP, is a Comprehensive Primary Care Physician and Family Medicine Department Chair at Adventist HealthCare Shady Grove Medical Center. You can hear her MedCast interview on Apple Podcasts, Amazon Music, Spotify, and Google Podcasts. She will be speaking about Private Practice Sustainability at the Empowerment Summit on November 5, 2022.

Nine Steps, continued from pg. 11

Step Seven: Review practice financial reports. Set aside at least four hours a month to review productivity, denials, and other reports that can help you understand where peaks and valleys in revenue occur and why. Monitoring your revenue, along with operating costs, is a proven step towards maintaining a successful and growing practice.

Step Eight: Total patient experience. The patient experience encompasses the range of interactions from the first phone call to the final payment. Demonstrating care and compassion towards patients begins at “hello”. A positive experience throughout the entire process ensures the likeliness of repeat business and patient referrals. This will also generate positive reviews on public-facing platforms such as webmd.com, vitals.com, healthgrades.com and Google reviews. In the age of social media, your reputation is your calling card; you cannot afford to be abrupt or dismissive.

Step Nine: Believe in yourself and your vision, and most importantly, be patient. Take your time when you are building the foundation of your practice. This step may take longer than you anticipated, but when done properly will set your practice up for long-term success. And remember, you do not have to go it alone. Surround yourself with top-notch professionals who can help you achieve your goals.

Kate Gilman, CPC, CPCO is Operations Executive with Medical Business Partners, LLC and can be reached at kate@medicalbusinesspartners.com.
MCMS Conducts Survey of Post-COVID Member Priorities and Expectations to Determine How to Best Serve Physician Members

Susan D’Antoni, FAAMSE

Given the changes in priorities that many have experienced because of COVID, the intent of this survey was to determine how physician members’ priorities have changed, how they were feeling about the COVID experience and looking forward, and what they expect out of their medical societies.

Ninety-five (95) physicians responded to the survey which is an approximate 10 percent response. Sixty-five percent were in full-time practice, and 58 percent were in solo and small groups. 48 percent were forty-six years old and over; 57 percent male and 43 percent female.

Physician Member Priorities — The survey included a list of possible priorities and members were encouraged to choose all relevant responses. With the reported increased burnout rate especially due to the challenges of COVID, it was reassuring to see that 53 percent are more focused on personal health & well-being, 51 percent are spending more time with family and friends and 33 percent want to travel more. Of particular concern to MCMS is that 32 percent expect to spend less time practicing medicine and professional endeavors and 31 percent will go to fewer medical meetings. 27 percent said their priorities have not changed.

Current Mindset About Medicine — As we move forward and hopefully out of the pandemic, 46 percent are proud to be a physician and proud of how their practice survived the pandemic. 44 percent are uncertain about the future of medicine, and 37 percent are not pleased with the direction of Medicine and are concerned for their patients.

Expectations of MCMS and MedChi and How We Serve Physicians — Another list of possible responses was provided to physicians and the top ten ways in which they want to see MCMS and MedChi resources allocated are:

1. Lobbying/Advocacy
2. Advocacy with Payors
3. Identifying and Addressing the Causes of Physician Burnout
4. Professional Satisfaction and physician wellbeing confidential complimentary counseling and/or coaching
5. Contract negotiations (improving contract negotiation skills with payors and/or employers)
5-tie. Practice support (assistance with answering practice-related questions)
6. Human resource issues (recruiting, managing, retention)
6-tie. Saving money through group purchasing options
7. Legal services (education, personal and professional legal referrals, contract negotiation)
8. Education (CME, socioeconomic factors impacting my practice & practice management topics)
9. Support and assistance with practice transitions
9-tie. Leadership Development & succession Planning
10. Advising on personal and professional financial planning
10-tie. Public health initiatives (implicit bias and cultural competency)

Volunteer activities, assistance with marketing medical practices and assistance with technology in their practice and hospital also were ranked highly.

Consideration of Major Transition in the Next 12 Months — We have seen significant change in our medical community including mergers, equity buy-outs, and retirements. MCMS asked physicians if they planned a major transition during the next twelve months. 58 percent indicated they do not expect to make any major change in the next twelve months; however, 14 percent do plan to transition to part-time.

Preferred Medical Society Meeting Format — As a regional medical society, MCMS provides considerable opportunities for physicians to network with each other to build their practice base and to encourage collegiality. Given the resources required to do this effectively, MCMS asked physicians what meeting formats they are interested in. From the survey results, 43 percent of physician respondents want much smaller in-person targeted events, like Women in Medicine events or Early Career events or collegiality dinners and 41 percent want more CME in-person CME programs. Twenty-seven percent of physician respondents prefer online/virtual events, and only 27 percent prefer large format membership meetings with exhibitors, sponsors, speakers. Of interest also is that 16 percent of respondents will not attend any in person events.

Major Takeaways from the Survey — MCMS will continue to offer small group in-person meetings in the remainder of 2022 and 2023. It is unlikely, at least for the foreseeable future, that MCMS will host a large format meeting given its cost and the risk it takes from lack of member attendance. We will also continue to offer virtual-only activities. MCMS will continue to focus resources on advocacy and evaluate how we can offer services which will resonate with our membership.

The information and insights from the survey are helpful to MCMS for planning purposes. However, of concern is that continued on page 17
Commercial Real Estate Services for Healthcare

Meet the Team

Colin McGonigal
cmcgonigal@klnb.com | 443-377-8633

Shay Vogg
svogg@klnb.com | 443-465-7223

Chris Gentry
cgentry@klnb.com | 703-554-4888

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• Knowledge of the local market and medical spaces
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• Honest, transparent brokers who want what is best for you and your practice

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Lease Renewals
Relocations
Expansions
Additional Offices
Purchases
Practice Transitions

We help our clients avoid costly pitfalls, complications and delays

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MCMS Survey, continued from pg. 15

Our respondent demographics do not reflect our membership, or the medical community that we serve. The physicians who responded are typically supportive of MCMS and MedChi (more established practices, solo/small group) and are willing to complete surveys. Their expectations of how MCMS and MedChi can serve them are aligned with independent practice largely not the trend toward larger group practice.

These results raise strategic questions for MCMS and MedChi. How we resonate with early career physicians, employed physicians and those in large groups must be considered for medical societies to survive and to continue to provide value. With that said, we are fortunate that we continue to have a base of physicians who are supportive and engaged in the work of the Society. We look forward to continuing to serve all physicians needs.

One of the brightest opportunities coming from the survey results are that there are twenty-five physicians who are or may be interested in leadership roles in the future. We need those leaders to ensure a relevant and responsive organization in the future.

Susan D'Antoni, FAAMSE is CEO of Montgomery County Medical Society. She can be reached at sdantoni@montgomerymedicine.org.

Five Reasons to Fall into Autumn with BCMS

Lisa B. Williams

Summer has ended and the program schedule for Baltimore City Medical Society (BCMS) resumes. Here are five programs the BCMS board and staff welcome you to attend. Look for e-mails with details and reservation information for these and others on our website — www.bcmedicalsociety.org or call 410-625-0022.

1. Membership networking “Happy Hour Juice Bar” — October
2. 15th Annual Furlong Memorial Lecture — November 16, 6:00 p.m.
3. Meet the new City Delegation to the Maryland General Assembly — November
4. Membership “Fireside Chat” — November
5. Symposium: Shaping Policy within Organized Medicine — December

More on BCMS Foundation’s 50th Anniversary

In past issues we shared some of the ongoing work of the BCMS Foundation. In an upcoming issue, we will recap our grand and celebratory year. Created in 1972, the Foundation serves as the philanthropic arm to BCMS, and has offered and supported a range of programs and initiatives, highlighted by just these five.

1. BCMS Report, patient newsletter, distributed through members’ offices and public venues
2. Physician Community Service Award, with a $500 grant to the nominating organization
3. Choose Wisely: Live Healthy — elementary school-based obesity prevention initiative funded by CareFirst
4. Medical school scholarships to 217 students, totaling over $500,000
5. Community Health Advocates, partnering with the Association of Black Cardiologists to teach, peer-to-peer, about healthy hearts

To learn more about the BCMS Foundation, visit www.bcmedicalsociety.org.

Lisa B. Williams is the CEO/Executive Director of the Baltimore City Medical Society. She can be reached at info@bcmedicalsociety.org.

St. Mary’s County Medical Society Welcomes New President Ann Banfield, MD

St. Mary’s County Medical Society is pleased to introduce their new president, Ann Banfield, MD. Her current position at Medstar St. Mary’s Hospital is that of Administrative and Clinical Director of Obstetrics and Gynecology. Prior to coming to Maryland, Dr. Banfield held the position of Treasurer for the West Virginia State Medical Society. Dr. Banfield is eager to become acquainted with her colleagues, recruit for the St. Mary’s County Medical Society, and participate in MedChi’s upcoming House of Delegates meeting next month.

Allegany County Medical Society Meeting, December 7th

Dennis Dey, MD, President of The Allegany County Medical Society invites you to join us on Wednesday, December 7, at University of Pittsburgh Medical Center, 12500 Willowbrook Road, Rooms 1-5. Dinner will start at 5:30 p.m. followed by presentations from MedChi CEO Gene Ransom and Delegate Michael W. Mc Kay, representing Allegany County. For information and registration, contact Cathy Peters at cpeters@medchi.org.
VALUABLE

HELPING ONE PHYSICIAN HELPS A THOUSAND PATIENTS.

That’s why nearly 80% of hospitals in Maryland support MPHP. MPHP is part of the Center for a Healthy Maryland, a 501(c)(3) charitable affiliate of MedChi, The Maryland State Medical Society, and was established to assist, support and provide advocacy as appropriate for physicians to address any potential conditions that may affect their ability to practice medicine in a safe and competent manner. MPHP understands physician-specific issues and offers an array of resources to assist.

MedChi, The Maryland State Medical Society, established the Maryland Physician Health Program (MPHP) in 1978 by physicians, for physicians.

REMEMBER, YOU ARE NOT ALONE

MedChi
The Maryland State Medical Society

MPHP
MARYLAND PHYSICIAN HEALTH PROGRAM

www.healthymaryland.org

1202 Maryland Avenue, 2nd Floor / Baltimore, Maryland 21201-5512 / P 410.962.5580 / 800.992.7010 / F 410.962.5583
Everyone knows what Plastic Surgery is. But there was no such thing before World War 1 when soldiers on both sides were being shot in the face. Those who survived tried to cope with the disfiguring effects of lost eyes, noses, and jaws. Soldiers who lost legs or arms were hailed as "Heroes of the War," but those with facial disfigurement were shunned aside. Because of their hideous injuries, no one wanted to look at them.

Enter Dr. Harold Gillies, a young surgeon in London who was awarded a position in otorhinolaryngology (Ears, Nose and Throat — ENT) not because of his surgical skills, but because he was an avid and accomplished golfer who often played golf with the chief of service. When the war broke out in 1915, he enlisted to help in the war effort. He was sent to France, where he began to tend to the injured. There he met Dr. Charles Valadier, a French dentist who outfitted his silver convertible Rolls Royce with a dental chair and drove around performing dental work on the injured soldiers. Dr. Valadier was known for treating "trench mouth," a commonplace problem of English soldiers even before the war, due to poor oral hygiene. Valadier became an expert at repairing the mandibles and maxillae of soldiers with facial injuries, but realized that the soft tissue coverage was just as important for any type of cosmetic result.

Infections were rampant, with mortality rates up to 35 percent. Gillies and Valadier worked to correct the soft tissue defects, after figuring out how to reconstruct the underlying bony tissue with bone grafts. Eventually, Gillies arranged for a special hospital back in England that was dedicated solely for the reconstruction of facial injuries.

Gillies established the Facial Unit at Cambridge Military Hospital in 1916 and arranged for many of these patients to be transferred to his care. He often had to undo the wound closures done in the field in order to clean the wounds and begin to allow healing. He developed the technique of transferring a flap of skin with its own blood supply to cover a wound and closing the subsequent defect. For those who were unable to swallow, he addressed the issue of adequate nutrition.

As time went on, Gillies developed more sophisticated techniques for reconstruction. While he lost many patients, many more survived and were able to return to society. He was greatly devoted to his patients, and they to him. A few stayed on and became his secretary and assistants. His surgical assistants and mentees went on to become distinguished professors of Plastic Surgery.

Lindsey Fitzharris, PhD, a medical historian, writes in a conversational style, and the book's timeline unfolds as an engrossing read. The Facemaker is not her first book, but a sequel to her first nonfiction work, The Butchering Art, Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine (2017). An expat American living in Britain, Fitzharris is best-known as the host of the Smithsonian Channel TV Series “The Curious Life and Death Of . . .” Like her TV series, these books are fascinating for physicians and laymen alike.
BHIPP TeleECHO Clinics

What are BHIPP TeleECHO Clinics?
BHIPP TeleECHO Clinics are a web-based learning collaborative that connects behavioral health experts with primary care providers to provide case-based learning and didactic presentations.

What are the goals of BHIPP TeleECHO Clinics?
The goal of BHIPP TeleECHO Clinics is to improve providers’ knowledge of mental health screening, evaluation, and in-office interventions, with an emphasis on both behavioral and pharmacological treatments.

Who can participate in BHIPP TeleECHO Clinics?
Pediatric primary care providers and care teams (e.g., pediatricians, family physicians, nurse practitioners, physician assistants, registered nurses, social workers, practice managers) are welcome and highly encouraged to participate.

BHIPP TeleECHO Clinics are made possible through funding from the Maryland Department of Health, Behavioral Health Administration and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of award U4CMC32913-01-00. The content are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.
PATIENTS ARE ASKING FOR PROTON THERAPY.
Here’s why.

Proton therapy isn’t just saving lives, it’s making the quality of those lives better. This technology targets solid, localized tumors and spares healthy tissues and organs, causing fewer side effects. If you have a cancer patient who qualifies, consider a referral to the Maryland Proton Treatment Center – the region’s leader.

FIND OUT MORE!
Visit AskForProtons.com/physicians
Or call 410-369-5200

Join MedChi on Figure1!
As a MedChi member you can access Figure1’s award winning global platform and join a private group built exclusively for our community. This private community provides a safe and convenient way to collaborate on medical cases with colleagues, and receive the latest communications from MedChi.

Scan this code to join the MedChi group and receive a free t-shirt!
MedChi’s Newest Physician Members

*MedChi welcomes the following new members, who joined between June 30, 2022, and September 7, 2022.*

Victor P. Abdow, MD — Abdow Friendship Pediatrics  
Robert Ball, MD  
Marsha Y Blakeslee, DO  
Justin Caplan, MD — Johns Hopkins University School of Medicine  
Ruby Chang, MD — Advanced Radiology  
Andrew Chen, MD — Advanced Radiology  
Marcin Czarniecki, MD — Advanced Radiology  
Christine Ann DeWitt, MD — MedStar Georgetown/Washington Hospital  
Edward Gelber, MD — Maryland Minds, LLC  
Paula M. Gregory, DO  
Lola Idowu, MD — University of Maryland Eye Associates  
Mark D. Klaiman, MD — Mark D. Klaiman, MD, LC  
Oscar Morales, MD  
Roberto Rosario, MD  
R. David Rose, MD  
Naheed F. Saif, MD  
Laura L. Steele, MD — MedStar Franklin Square Medical Center  
Heather Suss, MD  
Alula Tesfay, MD — Advanced Radiology

MedChi Events

*A complete list of MedChi and component events can be found at: [http://www.medchi.org/Calendar-of-Events](http://www.medchi.org/Calendar-of-Events).*

**NOVEMBER**  
2: Baltimore County Medical Association Board of Governor’s Meeting  
3: Washington County Medical Society Monthly Meeting  
5: MedChi’s 2022 Annual Meeting: Physician Empowerment Summit & House of Delegates Meeting  
9: Baltimore City Medical Society Board of Directors’ Meeting  
16: 15th Anniversary Furlong Memorial Lecture, joint meeting with Baltimore City Medical Society and Baltimore County Medical Association  
16: Baltimore County Medical Association CME Program  
18–22: The Mid-Atlantic Society for Post-Acute and Long-Term Care Medicine (MMDA) Annual Conference  
19: Maryland Neurosurgical Society Annual Meeting: November 19

**DECEMBER**  
2: Baltimore County Medical Association Legislative Breakfast  
7: Allegany County Medical Society Meeting  
11: Baltimore County Medical Association Holiday Brunch  
14: Baltimore City Medical Society Board of Directors’ Meeting
The History of Maryland Medicine Magazine
Meg Fairfax Fielding

Maryland Medicine, our medical journal, has a long and storied history, dating back to 1839. However, its path to the current iteration has been neither straight nor continuous.

In October of 1839, the Maryland & Surgical Journal was established by the Medical & Chirurgical Faculty of Maryland. It was also an official publication of the Medical Department of the United States Army and Navy. This iteration was published "regularly" until March of 1843. There is no record of what "regularly" meant, nor have we found any of these early journals.

For the next thirty-four years, there were no medical journals published in Maryland. In May of 1877, the Maryland Medical Journal published its very first issue, which was co-edited by H.E.T. Manning, MD, and T.A. Ashby, MD. In 1880, the journal began publishing on the first and fifteenth of the month. Over time, publication ramped up to printing on a weekly basis! Upon the publication of Volume VII, No. 12, Dr. Ashby reported that the Maryland Medical Journal had existed longer than any other journal in Maryland.

In 1918, shortly after World War I, the Maryland Medical Journal ceased publication. Over the next several decades, there were occasional newsletters, bulletins, and other publications, but nothing that was published on a set schedule with appointed editors and writers, and advertising.

At the end of 1951, the Faculty announced that a new magazine would commence publication in January of 1952 to "more effectively serve the membership."

All of the pre-1900 Maryland Medical Journals and a number of Journals from the late 1900s can be viewed online at medchi.org/News-and-Publications/MarylandMedicalJournalArchives (search for "Maryland Medical Journal"). Not all years have the entire run available, but the Center for a Healthy Maryland is working under a grant to fill in the missing issues.

Medcast, the Podcast from MedChi

Serial. This American Life. RadioLab. Seems like everyone’s got a podcast. But did you know MedChi also has a podcast? Earlier this year, MedChi launched Season 1 of MedCast, the Podcast. In the first ten episodes, host and past MedChi President Stephen Rockower, MD, sat down with some of the most influential and interesting physicians working in Maryland today.

Highlights from our first season include the intersection of politics and health care (Clarence Lam, MD; Terri Hill, MD; and Ben Lowentritt, MD); the challenges facing women in medicine and why MedChi’s recently formed IDEA Task Force (Inclusion, Diversity, Empowerment, and Advocacy) is more relevant now than ever (Tuesday Cook, MD; Carolyn O’Conor, MD; and Willarda Edwards, MD); the dangers of overprescribing pain killers and opioids (Gary Pushkin, MD); and what fourth-year residency is like during the Covid era (Karen Dionesotes, MD). Kicking things off was a candid interview with MedChi’s current president, Loralie Ma, MD.

It’s not too late to download any one or all of these podcasts, currently available on Apple Podcasts, Amazon Music, Google Podcasts, and Spotify.
Are you maximizing your MedChi membership?

The Maryland State Medical Society has exclusive benefits just for members. These products and services offer cost savings for you and your practice. Visit www.medchi.org/advantage for a list of benefits.

**Figure1** is a complimentary app that allows physicians to share cases and photos with physicians worldwide in a HIPAA-compliant atmosphere.

Want $100? Become a Tower Federal member and use code MEDCHI2022 when opening your account to receive $100. No catch, no strings. *Through 12/2022*

**Agility** gives a 5% discount on purchases of OTC COVID tests, KN95 and N95 masks, nitrite gloves, and other PPE that is already competitively priced.

Help patients save money while also supporting Children’s Miracle Network Hospitals. **Rx4Miracles** offers free prescription savings cards to all members and their patients.

**DealMed** offers excellent discounts on their medical, office, and surgical supplies through their website.

For more information about our benefits, visit www.medchi.org/advantage or contact the Membership team at members@medchi.org or 1-800-492-1056.